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Towards nursing competencies in spiritual care

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9

Chapter

General discussion, Summary, Samenvatting



General discussion

Introduction

The studies included in this thesis will answer the research questions formulated in the general introduction. The importance of spiritual care in health care in general and in nursing in particular is confirmed by the results of these studies. The interviews with patients, nurses and hospital chaplains have made clear that there is a connection between spirituality and illness and that this connection can be characterized as multidimensional. It has also become clear which competencies nurses might be expected to show in the spiritual care they provide to patients. With this study a valid and reliable assessment tool was developed to measure the competencies. Finally, this study provides insight into the effects of education on the development of these competencies in student nurses. In this chapter, the results will first be summarized by answering the research questions and then discussed.

Main findings

1. How has the connection between spirituality and physical health been investigated and what are the results of that investigation?

The first study comprised an analysis of 31 medical and nursing studies on the connection between spirituality and health among patients with physical illnesses (Chapter 2). The medical studies focused particularly on revealing a statistically significant relationship between spirituality and health. The nursing studies focused on the exploration of the beliefs, experiences and needs of patients in the area of physical health care. The analysis of the studies showed no common connection between spirituality and physical health. The results show either a positive or negative or even no connection. Comparative analysis is difficult because of the differences in methodology. One main problem is the operationalization of the concept of spirituality, which ranges from a specific religious content to entirely personal interpretations. In addition, in many of the studies the research questions were not focused directly on spirituality itself; the results in this area are measured as a side effect. These aspects need to be addressed in follow-up research.

2. What role does spirituality play in patients during physical illness and treatment?

The second study contains the results of focus group research with patients, nurses and hospital chaplains working in cardiology, oncology or neurology in Dutch health care. The results of this study show the relevance of spirituality to patients during illness and their subjective and personal interpretations. The multidimensionality of spirituality within the context of illness and treatment is confirmed. This study describes the relationship between spirituality and illness in themes. After concluding the analytical phase of the research, the themes that emerged were modelled in an adaptation of Fitchett's (1993) model of spiritual categories (Jochemsen et al., 2002). This model can be used by health care workers to assess the spiritual needs of patients.

3. What competencies do nurses need to provide spiritual care?

The third study is a literature review of the competencies that nurses need to provide spiritual care (Chapter 4). This resulted in the creation of a competence profile for spiritual care by nurses, covering three domains of competencies. The first domain, self handling, contains two competencies, one on the way a nurse personally copes with spirituality in the relationship with the patient, the other on the communicative aspects of spiritual care. The second domain, covering the spiritual dimensions of the nursing process, contains three competencies: spiritual needs assessment, nursing interventions and coordination of spiritual care. The third domain concerns the role of the nurse in quality assurance and the development of spiritual care policy in the health care institution. These competencies give direction to educational programmes on spiritual care in nursing.

4. How do nurses handle spiritual aspects in health care practice and can nursing competencies for spiritual be identified in their conduct?

The fourth study explores the way in which health care nurses handle the spiritual needs of patients (Chapter 5). The data resulted from focus group interviews with nurses, patients and hospital chaplains working in cardiology, oncology or neurology in Dutch health care. The results show that spiritual care is not

systematically embedded in nursing health care practice. The competencies for spiritual care provision derived from nursing theory (Chapter 4) were generally identified in practice but not in each individual nurse. The results show that personal factors play an important role in the concern nurses have for spiritual care. These factors are age, life experience, working experience and spiritual engagement. This study also demonstrates the different expectations of spiritual care between individual nurses, as well as among the groups of nurses, patients and hospital chaplains included in this study.

5. How can nursing competencies regarding the delivery of spiritual care be assessed?

The fifth study describes the development of a tool that measures competencies in nursing care, the Spiritual Care Competence Scale (SCCS) (Chapter 6). The basis for this tool was the profile of nursing competencies for the delivery of spiritual care (Chapter 5). Construct validity was determined by factor analysis. The tool consists of six subscales describing the following dimensions of competencies:

- assessment and implementation of spiritual care
- professionalization and quality improvement of spiritual care
- personal counselling and support of patients
- referral to professionals
- attitude towards patient's spirituality
- communication

The instrument was tested psychometrically in a group of nursing students. The subscales showed good internal consistency, adequate average inter-item correlations and good test-retest reliability. The results lead to the conclusion that the SCCS is a valid and reliable tool for the assessment of competencies for spiritual care on the group level, for instance in nursing teams or educational groups. For a broader (valid and reliable) application of this instrument, further testing is necessary in other nursing populations as well as among other health care workers (e.g. physicians, paramedics and social workers).

6. What are the effects of a newly developed educational programme for student nurses on the development of their competencies in spiritual care?

The sixth study describes the results of an evaluation of the effects on third-year students in two Dutch nursing schools of an educational programme on spiritual care aimed at the development of competencies to provide spiritual care. The evaluation involved the use of the Spiritual Care Competence Scale (SCCS) as well as assessments of vignettes. The vignettes consisted of two patient-related cases, one with implicit spiritual content and the other with explicit spiritual content. The students were asked to assess these cases and to state what care they should deliver in the given case. In the first phase of the research the students were divided into an intervention group and a control group. The intervention group followed the educational programme on spiritual care. The first assessment with the SCCS at baseline (T_0) showed no statistical differences between the intervention group and the control group. After finishing the educational programme (six weeks after baseline), the intervention group showed statistically significant higher scores on the subscales of 'Professionalization and improving quality of spiritual care' and on 'Referral to professionals' (T_1). Fourteen weeks after baseline the original control group also followed the educational programme on spiritual care. After they had finished the programme (20 weeks after baseline), the total cohort of students (original intervention group and control group) scored statistically significantly higher on all subscales compared to baseline scores (T_1). The effects on the subscales of 'Attitude towards patient's spirituality' and 'Communication' were trivial.

The assessment of vignettes (at T_1 , six weeks after baseline) showed that the intervention group scored significantly better statistically on the vignette with explicit spiritual content. Assessment of the case with explicit spiritual content showed no statistically significant differences between the two groups.

Regression analysis showed that not having an internship is associated with higher scores on the attitude scales 'Assessment and implementation of spiritual care', 'Professionalization and improving quality of care' and 'Personal support and counselling of patients'. This indicates that not having an internship has a weaker identification in these domains of spiritual care. The students' personal experience of spiritual care in nursing practice led to statistically higher scores on the subscale

'Personal support and counselling of patients'. Students who show a more holistic attitude to nursing care scored statistically significantly higher on the subscale 'Referral to professionals'.

7. What are the learning effects of the educational method of thematic peer review on the development of competencies for spiritual care provision?

The seventh study is a document analysis investigating the learning effects of thematic (spiritual care) peer review in groups. These groups were part of a spiritual educational programme in which third-year students of two Dutch nursing schools participated. Reflective journals kept by the students were used for qualitative analysis. The analysis showed that students discussed subjects falling into three main themes: 'self handling in spirituality and spiritual care', 'delivering spiritual care to patients' and 'aspects of spiritual care policy in health care institutions'. The students mentioned different learning effects in their reflective journals. First, they noted an increasing awareness of the relevance of spirituality and spiritual care to nursing and how their own spirituality played a role. Secondly, they recorded their growing self-confidence in the delivery of spiritual care; some students demonstrated a new, change-directed attitude. Following Kolb's (1984) learning theory about experiential learning, the discussions in the peer-review groups were focused especially on the learning stages 'inclusion of factual experiences' and 'reflection on these experiences'. The stages 'abstraction of experiences' and 'experimenting with new behaviour' were seldomly found in the reflective journals. One reason why the students did not attain all the levels of reflection may be due to the relatively low number of group meetings. The students' psychological stage of development may be another explanation. In addition, tutor guidance might be required in this learning process but the reflective journals provided no information on this aspect of the teacher's role.

Reflections

Methodological reflections

Combining qualitative and quantitative research methods

A combination of qualitative and quantitative methods was employed by the research featured in this paper. Both methods should be complementary and thus contribute to more valid and reliable data (Polit & Hungler, 1997). Each study used a single research method. For example, the spiritual aspects of illness were investigated but no other method was used to validate the spiritual themes emerging from that research. Follow-up research can contribute to further (external) validation of these themes. A multi-method approach (method triangulation) shows discernible added value, particularly in studies of educational effects. The studies in this research used the following methods: quantitative analysis of students' self-assessments on the Spiritual Care Competence Scale; quantitative analysis of students' vignette assessments; and qualitative document analysis of the reflective journals students kept during a peer-review process. This combination of methods provides additional insights on the students' development of competencies compared with a study that had used only their self-assessments had been used. The multi-method approach provides deeper insight into the learning effects of education in spiritual care. Razum & Gerhardus (1999) state that method triangulation is most useful when contradicting results are welcome. The different studies on the effects of education showed partly contradicting results. In their self-assessments, students rated themselves consistently highly on the levels of competence development, whereas more nuances were apparent in the assessment of the vignettes and document analysis. A combination of methods is desirable when assessing the development of competencies for spiritual care. The conclusion that method triangulation strengthens analysis and improves knowledge about educational effects is confirmed by Magnusson et al. (2005) in their research on education. The multi-method is recommended for assessing the validity and reliability of the results of learning processes.

Generalizability of results

Internal validity and reliability of results is guaranteed by the way the various studies are conducted and confirmed. A question is whether the results of this study can be generalized to the total population of patients, nurses, hospital chaplains and nursing students?

Firstly, convenient samples were used for the focus group interviews. Since the respondents were not selected at random, there may have been some selection bias. It is also possible that respondents may have agreed to participate because of their higher than average interest in spirituality.

The group of patients participating in this study reflected Dutch society with its Judeo-Christian and humanistic roots. Individuals from other religious or spiritual backgrounds, especially those with an Islamic background (one million Dutch citizens) were not involved in the sample. This raises questions about the way the participants in these groups might have influenced the results of the study of the spiritual aspects of illness and the nurse's role in spiritual care. To prevent selection bias in follow-up research, the use of stratified, randomly assigned groups is recommended.

Secondly, did the students participating in the study on the effect of education on the development of competencies in spiritual care nursing represent adequately the total student population of the 19 Dutch nursing schools educating students at the same level? All these schools educate students according to generally accepted professional standards (Pool et al., 2001) but nationwide there is no common nursing curriculum. The schools are comparable to a certain degree, but each school may stress different aspects of its curriculum. According to age and gender, the sample of students used in this study is representative because all students attend nursing schools after secondary school and most are aged between 18 and 22. If part-time students had participated, the sample would have been less homogeneous and probably less representative.

Thirdly, in terms of the generalizability of results, the religious background of the participating students is a point of discussion. These students can be described as

strongly religious (Christians). This becomes clear in their following characteristics: weekly church attendance (94%); daily bible reading (85%); daily prayer (93%); participating in religious study groups (74%). When asked 'how spiritual do you think you are?' (scale 1 - 10), 72% of the students scored themselves 7 or higher. When asked 'to what extent is your daily life directed by your faith?' (scale 1 -10), 88% scored themselves 7 or higher. Comparable characteristics of students from other schools are unavailable, as far as we know, and students from other religious backgrounds and non-religious students were not included in the sample. Considering the above, it must be concluded that the sample is not representative of the whole student population in all respects. Whether that led to a certain bias in the results can only be answered by follow-up research that includes students from other nursing schools with various religious, nonreligious and spiritual backgrounds. The hypothesis can put forward that there will be more effect of the educational programme on students who have a lower scores on the spiritual and religious rating scales.

Spiritual Care Competence Scale (SCCS)

In this study a tool was developed to measure nursing competencies in spiritual care, the Spiritual Care Competence Scale (SCCS). This tool finds its theoretical base in the nursing competence profile for spiritual care that was developed and described in an earlier stage of this study. The construct validity of the SCCS was confirmed by factor analysis, which resulted in six subscales characterizing the core dimensions of competencies for spiritual care in nursing. The psychometric analysis was done on the basis of measurements in a respondents group limited according to its size and characteristics. This analysis made clear that the SCCS is a robust, valid and reliable scale. The original competencies described in the nursing competence profile for spiritual care were also identifiable in the SCCS, which provides a strong foundation for further testing. This should take place in other populations of nurses, such as graduate nurses and those working in other areas than somatic health care (e.g. mental health care, geriatric care, community care and paediatrics). In this context it would also be interesting to test the general character of the tool by applying the SCCS in non-nursing populations such as physicians, paramedics and social workers. McSherry (2006) and White (2006)

recommend taking a multidisciplinary approach to spiritual care and they suggest considering spiritual care a task not only for nurses but for other health care workers as well. Further development and application beyond nursing should contribute to advances in this multidisciplinary approach.

Conceptual reflections

The connection between spirituality and sickness and health

The general introduction to this study pointed out that both functional and substantial approaches to spirituality are relevant in nursing (Jochemsen et al. 2002; Donk et al. 2006). In the functional approach, spirituality is an aspect of human functioning standing alongside the physical, psychological and social aspects of functioning. The functional approach fits well with an integral, holistic approach to the patient. The substantial approach stresses the many and varied forms and expressions of spirituality and also emphasizes that individuals may have personal experiences or a personal interpretation of spirituality. The results of this study confirm that both approaches are indeed relevant to nursing.

The connection between spirituality and illness and health is clear in general (functional); specifically, however, for each patient spirituality is unique (substantial). Fitchett's (1993) model of spiritual categories and the modified form (Jochemsen et al. 2002) used in this study can serve as a functional frame of reference for nurses assessing the spiritual needs of patients. The interviews exposed spiritual themes that must be seen as examples of the substantial approach because they are more specific interpretations of general topics made by patients with specific illnesses (cardiology, oncology and neurology). Studies among other categories of patients show that other themes may emerge as well (Westrik 1998; Jochemsen, 2002; Ross, 2006; McSherry, 2007). The meaning spirituality has for patients can thus be explained to nurses and other health care workers. This suggests the use of care models and nursing models that make explicit the role of spirituality. These models can help health care workers and nurses to develop a truly holistic focus in the care they give to patients. Examples are the biological-psychological-social-spiritual care model (BPSS model) described by De Vries (2006) or the Neuman

systems model developed for nursing (Neuman, 2002). The BPSS model (De Vries, 2006) justifies why all the dimensions of being human receive attention in care. De Vries (2006) gave content to the spiritual dimension of the model from the perspective of mental health. Neuman's systems model (Neuman & Fawcett, 2002) views the patient as an open-client system, which consists of physiological, psychological, social-cultural, developmental and spiritual variables in constant interaction with the internal and external environment.

Lastly, how can the above remarks on the connection between spirituality and illness and health be related to the analysis of medical and nursing studies described in Chapter 2? That outcome showed no unequivocal connection between spirituality and health. A distinction must be made between the medical and the nursing studies. The medical study sought a significant statistical connection while the nursing study researched the qualitative sense of the connection. This very much dependent on concepts being used. The outcome of the nursing study can be seen as validation of the outcome of the focus group interviews in this study.

Spiritual care in nursing

The conclusion that there seems to be a connection between spirituality and illness and health, demonstrates the relevance of this subject to nursing. It has already been noted in the general introduction that concern for the patient's spirituality is often not a systematic part of the care nurses provide to their patients. The results of the focus group interviews (Chapter 5) confirm that. These interviews also demonstrated the expectations patients and other health care workers have of the nurse's role. These varied from marginal to no involvement (assessing spiritual needs and referral to the hospital chaplain) to actively supporting patients in their spiritual needs. Personal spirituality is apparently an important factor for the nurse when deciding whether or not to provide spiritual care. Spiritually engaged nurses or those who had undergone certain major life experiences (life events) seem to be more sensitive to the spiritual needs of patients. This result shows that the nurses' own spirituality and spiritual experiences influence the way they handle spiritual care in practice.

This conclusion is supported by the philosophy of nursing practice that says that nursing activity has both a constitutive and a regulative side (Jochemsen et al. 2006). The constitutive side describes the professional principles and norms fundamental to nursing practice (e.g. protocols, methods, laws, codes). The regulative side refers to personal motives, objectives, expectations, experiences of the nurse that inevitably play a role in the way the nurse provides spiritual care. This regulative side enables the nurse to make an individual assessment of practice and to act innovatively. When it comes to the regulative side of spiritual care practices, the results of this study demonstrated that the nurse's personal spirituality and experiences play an important role. This is also suggested by the analysis of the reflective journals of nursing students (Chapter 8). This means that the nurses' attitude towards spirituality influences the way they handle the spiritual needs of patients in health care practice. For example, a nurse with an aversion to spirituality can simply ignore a patient's spiritual needs. More awareness of the regulative side of nursing practice is important for nurses in general but it may be even more important when it comes to nurses' attitude toward spiritual care.

Nurse competencies for delivering spiritual care

In addition to the regulative side of nursing practice, something must be said about the constitutive side of that practice with regard to spiritual care. The constitutive side deals with the purpose of nursing practice and its fundamental principles and norms (Jochemsen, 2006). The goal of nursing practice in general, but of spiritual care practice in particular, can be described as the enhancement of health and wellbeing of patients. The connection between spirituality and illness and health in this study implies that health care workers should tend to this aspect in their care. The expectations placed on health care workers in general and on nurses in particular must be made clear. The competencies for the delivery of spiritual care developed in this study should be seen as contributing to the clarification of these principles, norms and rules of spiritual care in nursing practice. As far as can be gathered from the literature, this is the first time that professional responsibility for spiritual care is described in terms of competencies. Among responses to the competence profile already in the literature, McSherry (2006) states that the profile is a valuable attempt to describe the knowledge and skills of nurses in this area.

He suggests broadening the use of the profile to health care workers in general, pointing to the generic character of the profile. A study among Maltese nurses validated five of the six competencies listed in the profile (Chapter 3), with the exception of the competence regarding quality assurance and expertise (Baldacchino, 2006). The author explains that nursing managers were not included in the sample and that quality assurance is still in its infancy in Maltese nursing. Tiesinga (2006) found the competence profile a useful tool for collecting data on the nurses' spiritual care role in community care.

Despite the support for the competence profile, it is still under debate. Waaijman (2004) is critical of the competence approach to spirituality and spiritual care. In his opinion the essence of the caring relationship between the nurse and the patient is in danger when too strong an emphasis is put on spirituality as an aspect of care and on the competencies of the caregiver. In his opinion, this is expressed by the fact that competencies are formulated in hands-on activities and attitudes. However, he considers such aspects as 'relationship with the patient', 'to be concerned', 'in dialogue with the patient', all explicitly mentioned in the competence profile, as categories of competencies that cannot be formulated in practical activities or attitudes. He says, 'There remains an area in these categories that cannot be planned and where strictly spoken nobody is competent because we will always be surprised. The other person faces us, touches us in his need, and we cannot protect ourselves against it. At this point we are passive and in a certain sense "incompetent". We are kneeling. We cannot stand it. We are passive and patient' (Waaijman, 2004, p.23). Waaijman believes it is essential to be aware of this passive component in the caring relationship with the patient. In this context Waaijman cites Buber (1966) who wrote 'becoming Me, I say You', asking in his turn 'what, in the caring relationship, will say You (patient) are touching Me (nurse), You are of concern to Me?' (Waaijman, 2004). He concludes that because care is in essence relational, it cannot be fully planned. The caring relationship has an active and a passive component and both components together are the essence of the contact between nurse and patient.

However, one might ask if the competence approach supported by this study places emphasis only on the active side of spiritual care and ignores the passive side. A basis assumption for this study was the functional approach to spirituality

and spiritual care. In this context spiritual care is defined as caring for the spiritual needs of patients and spirituality is understood to be an aspect of human functioning. Waaijman points to the importance of the relational aspect in nursing in general and the passive side of that relationship in spiritual care in particular. With this statement he stresses what is important in spiritual care. To be in a real person-to-person relationship in spiritual care, nurses should be more aware of the passive side of the relationship. One of the hospital chaplains who participated in the focus group interviews mentioned the active, problem-solving attitude of nurses as a contra-indication for the delivery of spiritual care (Chapter 5). Spiritual care is often not about finding answers or solving problems but, for example, about closeness, expressing your own vulnerability or sensitivity. Nurses in the interviews (Chapter 5) mentioned explicit examples of situations in which they felt powerless or had intense emotions in contact with the patient. The passive side of the relationship emphasised by Waaijman (2004) is evident. Waaijman emphasizes that nurses should become more aware of the passive side. Such awareness can be explained as a competence itself or a part of a competence that nurses need to possess with regard to spiritual care.

The competence profile contains an item on handling one's own values, beliefs and feelings. The following description is part of that competence: 'To reflect on the interaction between one's own spirituality (values and convictions) and response to the care one provides, including feelings of frustration, distress, fear of illness, suffering and death, and the effects of personal experiences' (Van Leeuwen & Cusveller, 2004). The nurse needs to reflect on becoming more aware of this passive side of the caring relationship in spiritual care. It need not lead to answers or solutions. In this sense the passive side of spiritual care is part of the competence profile and complementary to the active side.

Limitations of nurses' professional responsibility in spiritual care

What are the limitations of nurses' professional responsibility with regard to spiritual care? For example, how far do nurses have to go in showing sensitivity and (lack of) authority in their relationships with patients and colleagues? According to

Waaijman (2004), not every aspect of spiritual care can be planned. The personal characteristics of the individual nurse will play a role, which implies that not every nurse can be expected to show the same conduct.

The competence profile shows no sharply defined demarcation of professional responsibility. The connectedness model described by Cone (1997) can be helpful in clarifying this responsibility. The model describes three stages in the nurses' role in providing spiritual care. The first two are respecting the patients' spirituality (stage 1) and assessing spiritual needs and providing spiritual care by supporting and encouraging the patient (stage 2). Stage 3 is when the interpersonal spiritual connectedness between nurse and patient arises. This stage goes beyond the general professional relationship between nurse and patient and can show mutual sensitivity, deepened spiritual experiences and heightened transcendental experiences. The model can be interpreted as follows: stages 1 and 2 describe the professional responsibility for spiritual care that might be expected from all nurses. In stage 3, whether the nurse will provide spiritual care depends on the personal relationship between the nurse and the patient. On the one hand, the model can be helpful by clarifying the nurse's professional responsibility for spiritual care. On the other hand it raises questions, especially in stage 3. According to this stage the spiritual care a nurse provides can be completely indistinguishable in the total care plan of the patient because it is something personal between nurse and patient. However, this care should also be transparent to make it possible to assess whether it is contributing to the health and wellbeing of the patient. The prospect of health and patient wellbeing (or the prospect of a humane process of dying) must be the objective in every health care situation. The value of Cone's (1997) model is that it makes clear that in spiritual care nursing, with the exception of a certain basic level of spiritual care, the same level of spiritual care cannot be expected from all nurses in all situations. The results of the focus group interviews on the nurse's role in spiritual care confirm this (Chapter 5). This is supported by Smit (2006) who distinguishes the following four layers in spiritual communication: 1. Sharing general facts (e.g. where do you live, what do you do for a living); 2. Expressing feelings in general (how do you feel); 3. Talking about the belief system (what and why do you believe); and 4. Sharing spirituality (interconnectedness on a spiritual level). There is an inner threshold before each subsequent layer. The author states that thresholds are the highest before layer 1 (Will I make contact with this person?)

and layer 3 (do we dare to be open to each other's souls?). This model suggests that spiritual care is not standardized, but that the content depends on the relationship between the patient and the nurse and their personal openness, sensitivity, etc. This seems an important conclusion about the professional responsibility of nurses according to spiritual care.

The influence of age and experience of nurses on their spiritual care giving

Other factors that should be noted in the discussion on responsibility in spiritual care are the age and experience of the nurse. The results of the focus group study of the nurse's role in spiritual care (Chapter 5) reveal that the age and experience of nurses influences their spiritual caregiving. Older nurses with more experience of life and work seem more open to aspects of spirituality in care. The study of the effects of a spiritual care educational programme also showed that specific experience in spiritual care nursing is a predictor of the level of competence, according to how the students assessed themselves (Chapter 7). The role of age and experience is also confirmed by other studies (Carroll, 2001; Stranahan, 2001; Narayanasamy et al. 2002). The question of what might be expected from novices or more advanced, expert nurses remains. Benner (1984) emphasizes the differences among nurses in general. The discussion section of the analysis of students' reflective journals (Chapter 8) refers to the stages of personal faith development (Fowler, 1981). Clearly, development of a personal faith (spirituality) and the competencies needed to reflect on that development starts by the mid-twenties. What consequences does this have on the development of competencies in spiritual care nursing in young adolescents in comparison with older and more experienced nurses? Follow-up research may shed more light on this aspect of competence development.

The influence of cultural and organisational aspects within the health care institution on spiritual care giving

This study also showed that nurses' professional responsibility in providing spiritual care is also influenced by the culture, organization and policy of health care institutions (Chapter 5). Evidently, when the institutional culture is not or less conducive to devoting time and attention to the spiritual support of patients, tending to spiritual aspects of care will be considered of minor importance or not important at all. The vision and attitude of managers is crucial. Speaking about competencies and competence development in spiritual care makes no sense if these factors are not taken into account in the relevant discussions and implementation processes in health care practices. Bakker (2004) mentions developments on the meso and macro levels of health care that can influence patient-centred care in general and spiritual care in particular. The main developments he mentions are the prime importance of profitability, efficiency, technological developments and legislation of health care. The author recognizes the importance of holistic client-centred care in health care organizations but states that only the hospital chaplain is responsible for spiritual care. Because of the factors mentioned above, Bakker deems it less realistic to make other health care workers such as nurses and physicians responsible for this care. In his opinion, education of health care workers with regard to spirituality and spiritual care is attractive but nonetheless illusory. Giving their view on institutional health care policy, Gribnau & Pijnenburg (2004) regard spiritual care as going beyond the task of only the hospital chaplain. They emphasize the importance of education in spiritual care for health care workers (e.g. nurses and physicians). A tool for measuring organizational preconditions for spiritual care in palliative care (Jochemsen et al. 2002, Jochemsen, 2005) provides an example of how spiritual care can be implemented on a systematic basis in health care institutions in order to help assure the quality of spiritual care. This research commonly advocates the importance of systematic integration of spiritual care in health care organizations, but there is no shared vision of the degree of responsibility health care workers should take in spiritual caregiving. As stated above, the vision of health care managers is crucial. In terms of the competencies required (Chapter 4), it is of great relevance that nurses should be able to influence the policy of health care

institutions. Various nurses participating in this study mentioned the importance of spiritual care, but also stated that they were given no time for it in practice. This leads to the question of how priorities are set in health care. In addition, how are nurses influenced by cultural and organizational influences so that they no longer act on important basic assumptions of nursing care, such as their holistic vision? It seems evident that in future discussions on the place of spiritual care in health care practice it is important to take an integral approach that connects professional aspects with social (increasing attention for spirituality in society), cultural and organizational aspects.

Assessment of competencies in the delivery of spiritual care and the effectiveness of education

This study provides insight into the way competence in spiritual care can be assessed. Watson et al. (2002) recommend a so-called multi-method approach, where assessment is done on the basis of different resources, such as self-assessment, simulations and clinical evaluation. The results of studies on the effects of an educational programme on spiritual care support this recommendation (Chapters 7 and 8). The following methods are used for competence assessment in this study: self-assessment, vignettes and analysis of reflective journals. Using a combination of methods in combination gives a more balanced picture of the development of competencies in students, but only from a limited perspective. Self-assessment covers the whole competence profile but it remains subjective. The vignettes offer an idea of the students' self-analytical and theoretical competencies in spiritual needs and care. The reflective journals show, in particular, their growing consciousness of spiritual matters. Despite this, this multi-method approach did not make evident which competencies students actually have in nursing practice. Other forms of assessment are necessary as it must be concluded that competence assessment is very complex. In the first place, the required level of competence should be clear (competence profile) and secondly, the methods required to assess various competencies need to be validated. There are no examples of competence assessments with regard to spiritual care in the literature. Shumway & Harden (2003) describe a systematic approach to competence assessment in the medical sector that may serve as an example for the development of a valid and reliable competence assessment tools in nursing.

Despite these considerations, we conclude that the educational programme created for this study and applied at two nursing schools had a positive effect on the development of competencies in the students involved. This educational programme serves as an example of good nursing education practice.

Finally, it must be noted that the role of the teacher was not explicitly addressed in this study. The teacher might have an important role in the learning process in education in spiritual care. Catanzaro et al. (2001), Lemmer (2002) and Meyer (2003) emphasize the value of the teacher as a role model familiar with spirituality and spiritual care. These researchers observed an uneasiness with these topics among teachers in nursing educational practice. It is unclear whether this phenomenon had any effect on the education of students in this study. As with the students, all the participating teachers can be characterized as Christians; they may be expected to be familiar with the subject and show some commitment to it. Nonetheless, these thoughts must remain hypotheses because the teacher's role was not investigated in this study – reason enough to include this topic in future research.

Implications and recommendations

This study firstly shows the importance of spirituality to health and the importance placed upon it in the context of Dutch health care, thus drawing a connection with international developments in this area. Secondly, this study makes a substantial contribution to the development and measurement of nursing competencies in spiritual care and the role of nursing education in that development. Based on the outcome of this study, we make the following recommendations:

1. Research into the connection between spirituality and health should be continued. Considering the multidimensionality of spirituality, research within homogeneous samples is important. A distinction must be made with regard to specific illnesses and spiritual backgrounds (e.g. research into the spiritual needs of Islamic children with cancer). The focus of this research should be on the effects of spirituality and spiritual care on the health and wellbeing of patients.

2. The issue of the place and content of spiritual care in health care and the competencies of health care workers in spiritual care should be discussed. The competence profile developed in this study can be used as a basis for this discussion which should include professional demands and social-cultural, organizational and personal aspects. With regard to personal aspects, further research should be done on the impact of developmental aspects (psychological and spiritual) on competencies for spiritual care in novice and expert nurses.
3. The spiritual categories model employed in this study can be used in health care practice for assessing the spiritual needs of patients. It helps health care workers to approach the spirituality and spiritual needs of patients according to the multidimensional character of spirituality.
4. The Spiritual Care Competence Scale (SCCS) developed in this study is a valid and reliable tool for the (self) assessment of competencies in spiritual care in nursing. It can be applied on the group level in nursing practice (teams) and in nursing education (learning groups). For further development of the SCCS, additional testing is recommended in other nursing populations (functions and work settings) and, in order to test the multidisciplinary character of the tool, in relevant populations of other health care workers, especially physicians, paramedics and social workers.
5. With regard to the assessment of competencies in the delivery of spiritual care, we recommend a multi-method approach varying from self-assessment to clinical evaluation.
6. Forms of experiential and reflective learning are essential in nursing education on spiritual care because consciousness of and the impact of personal experience plays a vital role in the way nurses (students) provide that care. Experimenting with new behaviour is important in developing competencies. Teachers must be able to coach students in the learning process and should serve as role models. They must have the expertise to stimulate students' reflection on experiences in spiritual care and new behaviour. The teacher's commitment to the subject of spirituality and spiritual care is a prerequisite.

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